

Case Number:	CM14-0080361		
Date Assigned:	07/18/2014	Date of Injury:	09/06/2007
Decision Date:	08/25/2014	UR Denial Date:	05/16/2014
Priority:	Standard	Application Received:	06/02/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 50-year-old male with a 9/6/07 date of injury, and status post lumbar spine multilevel discectomy 98 and L5-S1 laminectomy 5/5/04. At the time (5/16/14) of request for authorization for Gabapentin 600 mg #60, Venlafaxine HCL ER 37.5 mg #60, and Ketamine 5% cream, there is documentation of subjective (neuropathic pain significantly worsened since running out of medications, and increased numbness and tingling in the right leg) and objective (absent Achilles reflex on the right, decreased sensation in the right L4, L5 and S1 dermatomes, spasms and guarding in the lumbar spine) findings, current diagnoses (lumbar post laminectomy syndrome and lumbar disc displacement without myelopathy), and treatment to date (epidural steroid injections, spinal cord stimulation, and medications (including Cymbalta, Lyrica, and Ketamine cream). 5/21/14 medical report identifies that the patient utilizes Cymbalta and Lyrica with benefit and that these have been switched to Gabapentin and Venlafaxine as Lyrica and Cymbalta have not been authorized. In addition, 5/21/14 medical report identifies that this refractory case and that primary and secondary treatment options have been exhausted. Furthermore, 5/21/14 medical report identifies that the patient utilizes a very small amount of Ketamine cream intermittently as needed, and is tolerating it well without any side effects. Regarding the requested Ketamine 5% cream, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of Ketamine cream use to date.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Gabapentin 600mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines AEDs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (Gabapentin). Within the medical information available for review, there is documentation of diagnoses of lumbar post laminectomy syndrome and lumbar disc displacement without myelopathy. In addition, there is documentation of neuropathic pain. Therefore, based on guidelines and a review of the evidence, the request for Gabapentin 600 mg #60 is medically necessary.

Venlafaxine HCl ER 37.5mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 13-14. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness and Stress Chapter, Antidepressants.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of chronic pain, as criteria necessary to support the medical necessity of antidepressants. ODG identifies documentation of depression, as criteria necessary to support the medical necessity of antidepressants. Within the medical information available for review, there is documentation of diagnoses of lumbar post laminectomy syndrome and lumbar disc displacement without myelopathy. In addition, there is documentation of chronic pain. Therefore, based on guidelines and a review of the evidence, the request for Venlafaxine HCl ER 37.5mg #60 is medically necessary and appropriate.

Ketamine 5% cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 113.

Decision rationale: MTUS Chronic Pain Medical Treatment guidelines identify documentation of neuropathic pain when all primary and secondary options have been exhausted, as criteria

necessary to support the medical necessity of topical Ketamine. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of within the medical information available for review; there is documentation of diagnoses of lumbar post laminectomy syndrome and lumbar disc displacement without myelopathy. In addition, there is documentation of neuropathic pain. However, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of Ketamine cream use to date. Therefore, based on guidelines and a review of the evidence, the request for Ketamine 5% cream is not medically necessary